VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
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Virginia Department of Health TB Control Program
TB Risk Assessment Form (TB 512)

Patient name (L,F,M): _____ DOB: _____ Race: ____ Sex: ____

Address: _____ Social Security Number: _____

City, State, ZIP: _____ Home/Work #: _____

Cell #: _____ Language: _____ Patient Pregnant: ___No ___Yes; If Yes, LMP: _____

Country of Origin: _____ Year arrived in US (if applicable): _____ Interpreter needed: ___No ___Yes

I. Screen for TB Symptoms (Check all that apply)

___None (Skip to Section II, "Screen for Infection Risk")
___Cough for ≥ 3 weeks → Productive: ___YES ___NO
___Hemoptysis
___Fever, unexplained
___Unexplained weight loss
___Poor appetite
___Night sweats
___Fatigue
Evaluate these symptoms in context

Pediatric Patients (≤ 6 years of age):
___Wheezing
___Failure to thrive
___Decreased activity, playfulness and/or energy
___Lymph node swelling
___Personality changes

II. Screen for TB Infection Risk *(Check all that apply)*

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized.

A. Assess Risk for Acquiring LTBI
The Patient…
___is a current high risk contact of a person known or suspected to have TB disease: Name of Source case: _____
___has been in another country for - 3 or more months - where TB is common, and has been in the US for ≤ 5 years
___is a resident or an employee of a high TB risk congregate setting
___is a healthcare worker who serves high-risk clients
___is medically underserved
___has been homeless within the past two years
___is an infant, a child or an adolescent exposed to an adult(s) in high-risk categories
___injects illicit drugs or uses crack cocaine
___is a member of a group identified by the health department to be at an increased risk for TB infection
___needs baseline/annual screening approved by the health department

B. Assess Risk for Developing TB Disease if Infected
The Patient…
___is HIV positive
___has risk for HIV infection, but HIV status is unknown
___was recently infected with *Mycobacterium tuberculosis*
___has certain clinical conditions, placing them at higher risk for TB disease: _____
___injects illicit drugs (determine HIV status): _____
___has a history of inadequately treated TB
___is >10% below ideal body weight
___is on immunosuppressive therapy (this includes treatment for rheumatoid arthritis with drugs such as Humira, Remicaid, etc.)

History of BCG / TB Skin Test / TB Treatment:

History of prior BCG: ___NO ___YES → Year: _____
History of prior (+) TST: ____NO ___YES
Date of (+) TST _____ Reading: ____mm
CXR Date: _____ CXR result: ___ABN ___WNL
Dx: ___LTBI ___Disease
Tx Start: _____ Tx End: _____
Rx: _____
Completed: ___NO ___YES
Location of Tx: _____

III. Finding(s) *(Check all that apply)*

___Previous Treatment for LTBI and/or TB disease
___No risk factors for TB infection
___Risk(s) for infection and/or progression to disease
___Possible TB suspect
___previous positive TST, no prior treatment

IV. Action(s) *(Check all that apply)*

___Issued screening letter ___Issued sputum containers
___Referred for CXR ___Referred for medical evaluation
___Administered the Mantoux TB Skin Test
___Draw interferon-gamma release assay
___Other: _____

TST Placed	TST Read
Arm: ___Left ___Right Date/Time _____ POS#:_____	Date/Time _____ Induration _____mm POS#:_____

IGRA Type used: ___T-Spot ___QFT-G-IT

Date/Time drawn: _____

Result: ___Pos ___Neg ___Borderline/Indeterminate

Screener's signature:_____

Screener's name (print):_____

Screener's title:_____

Date: _____ Phone #:_____

Comments: _____

- I hereby authorize the doctors, nurses, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (PPD) or draw blood for an IGRA test from me or my child named above.
- I agree that the results of this test may be shared with other health care providers.
- The Deemed Consent for blood borne diseases has been explained to me and I understand it.
- I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.
- I understand that:
  - this information will be used by health care providers for care and for statistical purposes only.
  - this information will be kept confidential.
  - medical records must be kept at a minimum for 10 years after my last visit, 5 years after death; for minor children, 5 years after the age of 18, or 10 years after the last visit, whichever is greater.

X _____ Date: _____